IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8941

July 27, 2006

Nolan Hoffer, Administrator
Boise Health & Rehabilitation Center
1001 South Hilton Street
Boise, ID 83705

FILE COPY

Provider #: 135077

Dear Mr. Hoffer:

On **July 14, 2006**, a Recertification and Complaint Investigation survey was conducted at Boise Health & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute actual harm, but are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 9, 2006**. Failure to submit an acceptable PoC by **August 9, 2006**, may result in the imposition of civil monetary penalties by **August 29, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 14, 2007**, if substantial compliance is not achieved by that time.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so

indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **August 9, 2006**. If your request for informal dispute resolution is received after **August 9, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

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F 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey and complaint investigation of your facility. The surveyors conducting the survey were: Kimberly Heuman, RN, Team Coordinator Lea Stoltz, QMRP Celeste Rush, RN Nicole Martin, RN Diane Green, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocols DON = Director of Nursing CNA = Certified Nurse Aide ADL = Activities of Daily Living LN = Licensed Nurse	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, it was determined the facility did not ensure that 1 of 13	F 154	F 154 Boise Health and Rehabilitation formally requests IDR for this citation. IDENTIFIED RESIDENT: Resident #10: This resident was provided cited information in a language she could understand both during the survey process, and prior to the survey process. All other residents in the facility have the potential to be impacted by this citation. The facility has taken the following measures to assure ongoing compliance: • Residents who request information about care and treatment will receive this information timely.	

RECEIVED
AUG 09 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nelda Lafferty | TITLE: Executive Director | (X6) DATE: 8/9/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	Continued From page 1 sampled residents (#10) received medication information requested in language that could be easily understood. Findings include: Resident #10 was admitted 10/4/04 with diagnoses that included gastritis, hypertension and depression. The annual MDS assessment dated 6/20/06, indicated the resident had normal cognition and decision making abilities. On 7/10/06 at 8:30 am, the resident was sitting up on the edge of her bed with a sad facial expression. She appeared uncomfortable and depressed. She stated she had a sleepless night and was worried about her health. At 10:00 am, the resident continued to appear depressed. The resident's sister was visiting. The resident indicated that 4 days ago, on Friday 7/7/06, the resident had asked a staff person for a list of drugs and the reason for taking them. The sister indicated she and the resident wanted to review the medications the resident was receiving. The resident said the list was provided on that same day but the resident could not understand the verbiage used and asked that the information be written in simpler words. The resident and her sister both indicated they had no feed back information from staff on the problem since 7/7/06 and were concerned as to why it took so long to get the information. This resulted in unnecessary concern and stress for the resident. The list was not provided until after the surveyor asked a LN, on 7/12/06, why the list had not been provided. The LN did not provide a reason for the delay on providing the information to the resident.	F 154	• Residents who require information to be provided in terms they understand will have those requests met in a timely manner. • Nursing will provide information at the time of request. If additional information is requested, nursing will provide that information in a format resident requests as appropriate, and will document information provided in the medical record. QUALITY ASSURANCE AND MONITORING: • This process will be monitored through random resident audits and tracking of resident requests. • The Director of Nurses and Executive Director will assure ongoing compliance through visits with residents/families regarding requests and satisfaction of results. Identified areas of concern will be addressed as needed through the facility Performance Improvement process. Completion date: August 15, 2006	

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F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on a complaint from the public, observations, record review and staff and resident interviews, it was determined the facility did not ensure 7 of 13 sample residents (#'s 1, 3, 4, 5, 8, 9 and 11) were provided care which enhanced their dignity. Residents were not protected from public view or provided assistance with grooming to present a dignified appearance. Findings include: 1. During observations on 7/10/06 from 10:05 a.m. to 11:05 a.m. resident #1 was noted to be dressed in a gown and wearing an incontinent brief. The door to the room was open. She was uncovered, had her legs spread, and her brief was visible from the hallway. She remained in that condition until 11:05, at which time a LN entered the room and pulled the curtain around her bed. On 7/11/06 at 12:00 p.m., resident #1 was observed seated in the main hallway waiting to enter the dining room. She was observed to be wearing a blouse which was on backward, the tag visible at her neckline. According to her 6/29/06 MDS, resident #1 was totally dependent on staff for dressing. 2. During observation on 7/11/06 from 6:15 a.m. to 6:40 a.m. resident #5 was lying in bed on her left side. The door to the room and the privacy	F 241	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 241 IDENTIFIED RESIDENTS: Resident #1, #5, #9, #8, #3, #4: Identified areas of concern were addressed and corrected during the survey process. • #1: Covered appropriately; clothing concern corrected • # 5: Covered appropriately, privacy curtain initiated, personal care concerns addressed and resolved • # 8: Assigned for care giver assistance x2 when resident resistive to cares. When brought to the attention of management, staff were immediately reminded of the need to treat all residents with dignity and respect • #3: Personal care concerns addressed and resolved • # 4: Privacy provided during cares • #11: When brought to the attention of management, staff were immediately reminded of the	

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F 241	Continued From page 3 curtain were both open. Resident #5's buttocks were uncovered and visible from the hallway. At 6:40 a.m., a LN entered the room and pulled the curtain around the bed. 3. Resident #9 was admitted to the facility on 1/20/03 with diagnoses of Alzheimer's disease, hypothyroidism, cancer, and osteoporosis. Her 6/28/06 MDS indicated extensive assistance was required for personal hygiene and activities of daily living function had deteriorated. During observations on 7/10/06 intermittently from 10:12 a.m. - 12:55 p.m., 7/12/06 intermittently from 6:15 - 1:30 p.m., and on 7/13/06 from 8:00 - 9:30 a.m. resident #9 was noted to have multiple (8-10) long dark chin hairs present. The resident did not have her dignity enhanced when the chin hair was not removed. During interview with the DNS on 7/13/06 at 11:00 a.m. the noted incidents of dignity issues were shared. 4. Resident #11 was admitted 7/3/02 with diagnoses that included dementia with behaviors, hypertension, hypothyroidism and depressive disorder. The annual MDS assessment, dated 5/27/06, documented the resident had memory problems, had severely impaired cognition, was dependent for all cares and could hear. She was observed being fed on 7/11/06 at the noon meal. The resident reached out with her fingers toward the plate of food. The aide stated	F 241	need to treat all residents with dignity and respect This citation has the potential to impact all residents in the facility. The facility has taken the following measures to assure ongoing compliance: • Direct care staff educated regarding resident rights to dignity, privacy and respect • Nurse Managers educated regarding daily rounds of units, observations of residents, and taking immediate corrective action as needed • Managers re-educated regarding observations and interactive dialogue with staff to assure residents receive care and services to promote their rights QUALITY ASSURANCE AND MONITORING: • Daily rounds by Nurse Managers to assure resident rights to Dignity, Privacy and respect are consistently met • Ongoing education as needed to assure compliance is consistent • The Director of Nurses will assure ongoing compliance through rounds and observations. Identified areas of concern will be immediately addressed. Ongoing areas of concern will be addressed and resolved as needed in the facility Performance Improvement Committee. COMPLETION DATE: August 15, 2006	

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F 241	Continued From page 4 "Keep your fingers out of the food!" rather then gently moving the resident's hand away or offering the resident some item to hold. 5. Resident #8 was admitted 3/22/06 with diagnoses that included Alzheimer's disease, dementia, depression, hypertension and osteoporosis. The quarterly MDS, dated 6/18/06, indicated the resident had memory problems, her cognition was severely impaired and she was dependent for all cares. The care plan, with an update of 5/4/06, directed, "Allow time to respond and be aware of resident's hearing ability." The resident was observed on 7/10/06, at 10:30 am, while an aide provided personal care to the resident. The resident's incontinent status involved an extensive feces smear covering the front of the abdomen, peri area and entire buttocks. The aide was working alone while doing the incontinent procedure and the resident was continually crying out. The resident would make eye contact with the aide each time the aide said something which indicated the resident could hear. The aide did not seek help, and when the resident would reach out to grab the aides arm, the aide said "don't grab me" and at the same time, pushed the resident's hands away. When the resident would pull her legs up into a fetal position, the aide said "Keep your legs down" and at the same time would push the resident's legs down. 6. Resident #3 was admitted to the facility on 12/03/03 with diagnoses of open reduction	F 241		

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F 241	Continued From page 5	F 241		

internal fixation of right hip, pressure ulcer, MS (multiple- sclerosis) with quadriparesis, and CVA (cerebrovascular accident).

The resident's quarterly MDS, dated 4/19/06, documented the resident's cognition was moderately impaired and the resident was totally dependent for her ADLs, such as ambulating, dressing, and personal hygiene.

On 7/10/06 at 1:25 pm, several long chin hairs were observed on the resident. The chin hairs were again observed on 7/11/06 at 6:20 am, 7:20 am and 11:05 am; and on 7/12/06 at 9:15 am.

On 7/12/06 at 8:45 am, the DNS was interviewed. She acknowledged the problem and indicated that the chin hairs would be removed.

Observation on 7/12/06 at 10:00 am, noted a CNA was in the process of shaving the multiple (approximately 6-8), long, dark chin hairs that had been observed earlier. The resident stated, "Now I'm so pretty,"

7. Resident #4 was originally admitted to the facility on 8/30/03 and readmitted on 3/17/06 with diagnoses which included acute gastrointestinal bleed, COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), polymyalgia, and Schizoaffective Disorder.

Review of the resident's MDS, dated 2/8/06, indicated the resident had moderately impaired cognitive skills, displayed no negative behavioral symptoms, required extensive assistance with transfers, extensive assistance of one staff member with toilet use and was continent of both

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F 241	Continued From page 6 bowel and bladder function. On 7/10/06 at 10:45 am, 2 CNA's were observed to assist resident #4 with incontinence care. It was observed that while the CNAs were providing peri-care, the resident was turned to her right side in bed exposing her buttocks. A window to the outside was located to the left of the resident's bed. The vertical window blinds covering this window were closed during the cares, however, a gap approximately 6 to 8 inches in wide was observed. This allowed potential visualization of the resident from the outside. This is a repeat deficiency from the 6/10/05 recertification survey.	F 241		

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it was determined RAP's were not adequately used to assess the MDS triggered areas. This was true for 1 of 13 sampled residents (#11). Findings	F 272	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 272 The center strongly disagrees with the statement of deficiency and will request an informal dispute resolution process. However, notwithstanding the aforementioned, the center will continue to complete the following plan of correction as required. IDENTIFIED RESIDENT: • #11: RAP dated 6/6/06 has been reviewed. Facility has generated a current RAP for ADL's and Psychotropic medications which address identified concerns. This citation has the potential to impact all residents in the facility on medications. The following measures have been taken to assure ongoing compliance: • Residents who are having ADL raps completed will have Range of Motion and Restorative progress identified on the RAP as needed	

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F 272	Continued From page 8 include: The CMS's RAI Version 2.0 Manual - Ch 4 procedures for completing RAP's indicate the following: "The MDS identifies actual or potential problems areas. The RAP's provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAP's to analyze assessment findings and then "chart your thinking." 1 a. Resident #11 was admitted on 7/3/02 with diagnoses that included dementia with behaviors, hypertension, hypothyroidism and depressive disorder. The MDS annual assessment, dated 5/27/06, indicated the resident was unable to ambulate, was dependent for all cares and had range of motion limitations of one hand and arm. The resident was observed on 7/10, 7/11, 7/12/06 at 8:30 am and on 7/10, 7/11 and 7/12/06 at 11:45 am in the dining room, seated in a wheelchair, inactive and leaning to the right. During an observation of care on 7/12/06 at 9:30 am, staff stated the resident was "inactive and usually very stiff." The care plan directed, "Passive ROM and gentle massage to right wrist/hand for 10 Reps daily" and "splint to right UE [upper extremity] in am after performing PROM [passive range of motion], then to remove in pm."	F 272	• Residents on medication for behavior management will have Psychotropic Raps completed for any medications considered to be used for behavioral management, regardless of whether the medication meets the definition of "Psychotropic" medication. • Education regarding necessary documentation of information on resident RAPS has been reviewed with the MDS nurse QUALITY ASSURANCE AND MONITORING: • Utilization Review RN will review ADL and Psychotropic RAPS for implementation and completion • The Utilization Review RN and Director of Nurses will assure compliance through audits of RAPS. Identified areas of concern will be immediately corrected, and addressed as needed in the facility Performance Improvement committee. Date of Completion: August 15, 2006	

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F 272	Continued From page 9 The ADL RAP dated 6/6/06 documented, "Resident with severe dementia, dependant on staff to anticipate & meet needs. Restorative program - splint. OT [Occupational Therapist] recently evaluated and d'cd [discontinued] wheelchair positioning." The RAP documentation did not indicate the date of the OT's "recent evaluation" that addressed the resident's wheelchair positioning. The RAP gave no indication that ROM to all joints had been considered to address the resident's stiffness and inactive status. Even though there was a plan for ROM and gentle massage and splint to the right UE, documentation as to if the plan had been followed and the resident's response to the plan (regression/improvement/maintenance status) for the UE was not addressed in the RAP. This problem was brought to the attention of the MDS LN on 7/13/06 at 9:00 am. No further assessment information was provided. b. An order signed by the physician on 6/2/06, documented "Depakote Sprinkles 500 mg po BID [milligrams per mouth two times daily] for dementia with agitation." On 7/13/06, between 9:00 am and 10:30 am, the Social Worker validated the medication Depakote was administered to resident #11 for behavior control and the last Depakote drug reduction was 9 months ago, on 9/26/06. Assessment documentation was requested of the Social Worker and the MDS LN on 7/13/06 between 9:00 am and 10:30 am. Even though Depakote was given to this resident to control behaviors, the Social Worker indicated the Psychotropic Drug Use RAP had not been completed during the most recent full assessment (5/27/06).	F 272		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that care plans were not revised for 5 of 13 (#1, 4, 7, 8 and 11) sampled residents. The findings include: 1. Resident #7 was admitted to the facility on 12/3/04 and readmitted on 2/8/05 with diagnoses including cerebrovascular accident (CVA) with hemiparesis, insulin dependent diabetes mellitus and hypertension. The resident's care plan dated 5/22/06, indicated the resident had been identified as having	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 280 IDENTIFIED RESIDENTS: • # 1, 4, 7, 8, and 11: Care plans have been updated to reflect current plan of care All residents have the potential to be impacted by this citation. The facility has taken the following measures to assure ongoing compliance: • Resident care plans will be reviewed each quarter to assure plan of care reflects current status and changes • Facility will continue to utilize temporary care plans to address changes in plan of care • Nursing staff educated regarding utilizing temporary care plans to address changes in the resident's plan of care QUALITY ASSURANCE AND MONITORING:	

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F 280	Continued From page 11 "...Swallowing, impaired R/T [related to] S/P [status post] CVA R/T intermittent cough/choke after swallowing liquids R/T dysphagia..." Approaches documented, "Amount control cup for liquids in restorative dining room..." On 7/10/06 at 1:05 pm, 7/11/06 at 8:00 am and 12:30 pm, and 7/12/06 at 8:10 am, resident #7 was observed in the Teton dining room sitting at the third table from the doorway on the left hand side of the dining room as the surveyor was standing in the doorway facing into the dining room. On all occasions the resident was observed using a regular plastic glass to drink liquids and was independently eating meals with setup assistance only. On 7/13/06 at 9:17 am, the DON was interviewed. The DON explained that the facility did not have a designated restorative dining room but did have a table in the Teton dining room that was identified as a "restorative table." She stated the restorative table was the 1st table to the left as you entered the Teton dining room. The DON further acknowledged the resident had been sitting at a different table in the dining room and had not been observed using a control cup for liquids. She stated the resident no longer was assessed to need these interventions. 2. Resident #1 was admitted on 9/12/03 with diagnoses of MS (multiple sclerosis), diabetes mellitus, bi-polar disorder, dementia, stage IV pressure ulcer and chronic osteomyelitis. a. Resident #1's 5/16/06 Care Plan indicated, "skin integrity impaired: actual", and stated the	F 280	• Unit Manager Nurses will participate in care planning process and assure care plans are updated appropriately • UR nurse and Director of Nurses will monitor through Care Plan review. • Utilization Review RN and Director of Nurses will assure ongoing compliance through Care Plan Review. Identified areas of concern will be immediately resolved and addressed as needed in the facility Performance Improvement committee. Completion date: August 15, 2006	

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following, in part, under "approach": "pressure relieving gel cushion to bedside chair and/or wheelchair." The approach had been discontinued on 5/16/06 as indicated by a hand written note.

The DNS was interviewed on 7/13/06 at 11:00 a.m. and confirmed resident #1 still utilized a pressure relieving device when in the wheelchair, and the care plan should have included the current device.

b. Resident #1's 5/16/06 Care Plan indicated "7/12/05 provide vitamins and minerals as ordered." The 6/1/06 Physician's Orders did not include vitamin or mineral supplements.

The DNS was interviewed on 7/13/06 at 11:00 a.m. and confirmed resident #1 had received vitamin and mineral supplements in the past, but they had been discontinued.

c. Resident #1's 5/16/06 Care Plan indicated "risk for falls 10/9/05, pressure pad alarm when in bed and wheelchair to alert staff of attempts to transfer independently." and "place mats on floor on both sides of bed." The care plan also stated "7/26/05 transfer with mechanical lift using 2 person assist..."

The resident's 6/29/06 MDS stated total staff assistance was required for bed mobility, transfers and that she had not sustained a fall in the past 180 days. During observations on 7/10/06 intermittently between 10:05 a.m. and 2:30 p.m., and on 7/11/06 intermittently between 6:15 a.m. and 12:00 p.m.,
alarms and floor pads were not noted to be

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F 280	Continued From page 13 present. The DNS was interviewed on 7/13/06 at 11:00 a.m. and confirmed resident #1 had devices in place in the past, but they had been discontinued. 3. An incident report for resident #8, dated 4/14/06, documented, "resident rolled onto floor with bed in low position - mat was on the other side." Under recommendations it directed, "mats on both sides of bed on floor." The care plan, with an initial start date of 3/31/06, directed, "lo bed...and mats on floor." On 7/12/06 at 1:30 pm, the LN indicated the use of the mat had been changed and was to be placed on the floor on the side the resident was laying toward. The care plan had not been revised to address the change. 4. Resident #11's care plan indicated the resident was to be positioned "only on left side when back in bed- becomes restless if positioned on right side..." The resident was observed on 7/13/06 at 9:30 am, while in bed. After personal care, the CNA positioned the resident on her right side. On 7/13/06 at 10:00 am, the LN indicated the care plan had changed, the bed had been placed up against the wall and the resident now could to be placed on her right side. The care plan had not been updated. 5. Resident #4 was originally admitted to the	F 280		

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facility on 8/30/03 and readmitted on 3/17/06 with diagnoses which included acute gastrointestinal bleed, COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), polymyalgia, and schizoaffective disorder.

The resident's significant change MDS, dated 2/8/06, indicated the resident had moderately impaired cognitive skills, displayed no negative behavioral symptoms, required extensive assistance with transfers, extensive assistance of one staff member with toilet use, and was continent of both bowel and bladder function.

The quarterly MDS, dated 6/14/06, indicated the resident was still assessed as having moderately impaired cognitive skills, required extensive assistance with transfers, extensive assistance of one staff member with toilet use, and displayed no negative behavioral symptoms. However, the assessment now indicated the resident was frequently incontinent of bladder. No "Appliances and Programs" were checked in relation to toileting or bladder retraining and a "Urinary tract infection in last 30 days" was checked.

The resident's comprehensive care plan, dated 5/16/06, revealed a problem of "Self-Care Deficit: Toileting..." The documented approaches included, "Encourage resident to complete toileting task with extensive assist; Document Bowel Functions...; Bladder Document: C=Continent I=Incontinent."

An updated care plan, dated 7/11/06, documented a "Restorative Program Referral" related to a diagnosis of "urinary incontinence/weakness." The documented

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approaches included "UI [urinary incontinence] exercises, see attached sheet cont.[inue] exercises 4-6 x [times] week for 4 weeks 10 reps [repetitions] per exercise." Attached to this care plan was a "Pelvic Muscle Exercise Program."

On 7/11/06 at 6:15 am, the resident was observed in bed, on her back, asleep. The resident was observed in this same position at 6:55 am. From 6:55 am until 9:50 am, the resident's room was continuously observed. During this time frame, no direct care staff were observed to enter the resident's room to offer toileting or provide incontinence care to the resident.

On 7/11/06 at 10:00 am, a CNA was interviewed regarding the resident's morning routine. The CNA stated the resident did not like to get up before 10:30 am.

On 7/12/06 at 8:45 am, the DON was interviewed. The DON was informed of the surveyor's observations of the lack of toileting for resident #4. The DON stated that she would look into it.

On 7/12/06 at 1:00 pm, the DON and a LN, familiar with resident #4, were interviewed again. The DON acknowledged the decline in the resident's bladder functioning from being continent before her hospitalization and now being frequently incontinent. It was also stated the resident had a lot of issues with her bladder and that she did not feel the urge or need to go. It was also acknowledged the resident did not want to get up in the morning and would refuse cares when offered. The DON was asked to provide any documentation related to the resident's refusal of

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F 280	Continued From page 16 care related to toileting in the resident's plan of care. However, none was provided. Resident #4's care plan was not reviewed or revised to reflect the resident's refusal to allow staff to provide incontinence care on a regular basis to maintain the resident's previous continence status, or guide staff as to how to intervene when the resident refused care.	F 280	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility did not follow accepted standards of nursing practice. This deficient practice affected 1 of 5 LNs observed during the medication pass when a LN documented medications as given prior to 2 random residents (#16 and 17) receiving the medications. The findings include: On 7/10/06 at 2:15 pm, during the medication pass on the 300 hall, it was observed that a LN documented medications as given prior to the resident receiving them. The LN prepared the following medications, signed for the medications, and administered them to resident #16 and 17. a. Resident #16 received Glucosamine 500 mg (milligrams), 1 tablet.	F 281	F 281: IDENTIFIED RESIDENT: • # 16 and 17: Nurse passing medication educated regarding signing of medications This citation has the potential to impact all residents receiving medication in the facility. The following measures have been taken to assure ongoing compliance: • Nurses educated regarding medication pass, and signing of medications post administration, utilizing Informational Letter #97-3 • Nurse Managers educated regarding completion of Medication Pass audits, and expectations QUALITY ASSURANCE AND MONITORING: • Pharmacy Services and Nurse Managers will conduct random Medication Pass Audits	

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F 281	Continued From page 17 b. Resident #17 received Carbamazepine 100 mg, 1 tablet. OxyContin HCL (hydrochloride) 5 mg, 1 capsule. Ritalin, 10 mg, 1 tablet. On 4/16/97, informational letter #97-3 was sent to all Idaho Nursing Facilities by the Bureau of Facility Standards. The letter stated, "...the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually had taken the medication...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do...There are an unlimited number of ways a facility could meet this practice standard. One option would be to simply document only after the medication has been given. A facility could also choose to continue documenting the medication pour, provided that an additional system is developed to also document that the medications were given as poured. This additional system could be quite simple. For example, a small check could be made in the box at the time of the pour, and nurse's initials could be added after the medication was given."	F 281	• Director of Nurses or designee will conduct random Medication Pass Audits with Nurse Managers • Director of Nurses will monitor for ongoing compliance through review of Medication Pass Audits, and observation of Medication Passes. Identified areas of concern will be immediately addressed and reviewed as needed in the facility Performance Improvement committee. Date of Completion: August 15, 2006	

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to provide a resident with proper equipment (ted hose) according to physician orders. This deficient practice affected 1 of 13 sampled residents (#13) The findings include: 1. Resident #13 was admitted to the facility on 2/21/02 with diagnoses of CVA, HTN (hypertension), depressive disorder, and Alzheimer's disease. Resident #13's quarterly MDS dated 6/11/06, documented the resident's cognition was moderately impaired and he needed extensive assistance with ADLs (such as dressing and personal hygiene). A doctor's order dated 11/14/05 documented, "Ted hose q (every) day when up; to be put on at 0700 (7 am), then off at HS (night). On 7/12/06 at 1:30 pm, resident #13 was observed sitting in a wheelchair, outside his room in the hallway. The resident was not wearing ted hose.	F 309	F 309 IDENTIFIED RESIDENT: • # 13: Ted Hose applied per MD order. This citation has the potential to impact all residents with orders for ted hose. The following measures have been taken to assure ongoing compliance: • Residents with orders for ted hose and other devices have been reviewed to assure ongoing compliance • Unit Managers will complete consistent rounds to assure implementation of devices per MD order • Education provided to direct care staff regarding application of devices as ordered QUALITY ASSURANCE AND MONITORING • Medical Records will provide weekly printout of MD orders for devices for distribution to Nurse Managers for ongoing monitoring • Director of Nurses will assure ongoing compliance through random audits. Identified areas of concern will be corrected immediately and reviewed as needed in the facility Performance Improvement Committee Completion Date: 8/15/06 NH tel	

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F 309	Continued From page 19 On 7/12/06 at 2:15 pm, resident #13 was observed not wearing ted hose. On 7/13/06 at 7:50 am, resident #13 was observed in his wheelchair in the dining room not wearing ted hose. On 7/13/06 at 9:30 am, a CNA was interviewed. The CNA stated, "I have never seen the ted hose. As far as I know, I've never seen any on the resident." The facility did not ensure the resident wore his ted hose in a manner consistent with physician orders. This is a repeat deficiency from the 6/10/05 recertification survey.	F 309	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 312 IDENTIFIED RESIDENTS: # 6: Appointment set during survey process. Visiting Podiatrist had cancelled July visit. Visit rescheduled, and request to Podiatrist to meet with Director of Nurses when in facility. Resident has constant saliva on lower face due to lack of swallow response. Resident receives frequent care to address saliva. # 8 and 11: Fingernails have been trimmed and filed All residents requiring assistance with cares have the potential to be impacted by this citation. The following measures have been taken to assure ongoing compliance: • Podiatrist and Director of Nurses have established set schedule for Podiatry visits • Activities staff educated regarding assuring nails are filed and clean prior to application of nail polish	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents who required assistance with oral care, nail care and bathing, received the necessary assistance. This was true for 3 of 13 sampled residents (#'s 6, 8 and 11) . Findings include:	F 312		

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F 312	Continued From page 20 1. Resident #6 was admitted to the facility on 7/29/99 with diagnoses of subdural hematoma, coma, quadriplegia and depression. Resident #6's quarterly MDS dated 4/16/06, documented the resident's cognition pattern as comatose, personal hygiene as totally dependent, range of motion for hands as limited on both sides and voluntary movement for hands as full loss. The resident's "Bathing Self-Performance" was documented as "8 = Activity did not occur." The resident's care plan dated 2/9/06, documented, "...(7) Problem...Dressing/Grooming ...Goal...Finger and Toe Nails will be kept clean and trimmed...Approach...Requires total assist with grooming needs... (8)Problem...Bathing/Hygiene deficit...Goal...Resident will be groomed and bathed by staff per daily routine...Approach...(2) Resident is total care for all bathing and hygiene needs...(3) Oral hygiene q shift and prn [as needed] using toothettes D/T [due to] NPO [nothing by mouth] status. Ensure cleaning of sides of mouth..." a. Observation of resident #6 revealed the resident with dry lips covered with white caked on skin and saliva running down her chin on the following occasions: 7/10/06 at 10:16 am and 10:58 am, 7/11/06 at 6:23 am and continuous observation from 8:05 am through 9:55 am, 7/12/06 at 8:07 am and 9:05 am. On 7/13/06 at 9:07 am, 2 LNs stated they usually tried to give the resident oral care every 2 hours	F 312	• Facility Unit Managers will conduct routine rounds to audit and assure personal care concerns are identified and addressed consistently and timely QUALITY ASSURANCE AND MONITORING: • Nurse Managers will conduct routine rounds to assure resident care needs are addressed consistently • Director of Nurses will conduct random audits to assure ongoing compliance • Identified areas of concern will be resolved immediately and addressed as needed in the facility Performance Improvement committee Completion date: August 15, 2006	

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because she had dry skin that accumulated on her lips. The LNs stated they put vaseline on the resident's lips after providing oral care. They did not indicate the last time vaseline was applied to the resident's lips or if the vaseline was effective in relieving the resident's dry lips.

b. On 7/10/06 at 10:58 am, resident #6 was observed with thick, crusty fingernails on the 2nd and 3rd fingers of her right hand, and 2nd finger and thumb of her left hand. The fingernails were approximately 1/2" thick and ranged from 1" - 1 1/2" in length. The resident's left thumbnail was observed to be growing at a 90 degree angle away from the base of the thumbnail.

Review of the resident's record revealed a "Condition Change Form" dated 7/5/06 at 2:30 pm documenting, "...Difficulty cutting Lt [left] hand finger nails because of fungal infection. Request F/U [follow-up] c [with] pediatrist [sic]..."

On 7/10/06 at 11:20 am, the wound care nurse confirmed a referral was generated on 7/5/06 for podiatry services. She stated the facility transporter usually scheduled resident appointments outside the facility.

On 7/10/06 at 11:25 am, the surveyor observed the transporter phoning and scheduling a podiatry appointment for the resident for 7/19/06 at 9:30 am.

c. Review of flow sheet records from 4/1/06 through 6/30/06 listed each day of the month with spaces to initial if bathing occurred. The following documentation indicated a lack of showers/baths between the following dates:

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F 312	Continued From page 22 4/8, 4/20 - 12 days between showers/baths 4/20, 4/27 - 7 days between showers/baths 5/3, 5/11 - 8 days between showers/baths 5/16, 5/24 - 8 days between showers/baths 5/31, 6/7 - 7 days between showers/baths 6/11, 6/25 - 14 days between showers/baths On 7/13/06 at 8:15 am, the MDS nurse stated, "If the MDS documented "8" for bathing it was because there was no documentation to support that bathing had occurred. On 7/13/06 at 9:17 am, the DON was interviewed. The DON stated she was not employed by the facility during the months of April and May 2006 and was unable to verify if showers/baths had actually occurred. 2. Resident #11 was observed on 7/10/06 at 8:30 am and on 7/13/06 at 9:30 am and was noted to be dependent for all cares. Her fingernails were long, jagged and rough. This resulted in the potential for accidental skin breaks from her rough, sharp fingernails. The care plan, with an update of 6/15/06, directed "trim and file fingernails every bath day to prevent resident from scratching herself." 3. Resident #8 was observed at 10:30 am on 7/10/06 while an aide was providing personal care. The resident was observed to be dependent for all cares. The resident's finger nails were observed long, jagged and rough. The resident's right hand was continuously held in a tight fist position. The nails on the left hand had been freshly polished. The aide indicated the resident had a feces odor, needed incontinent care and for that reason had been removed from the nail care	F 312		

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F 312	Continued From page 23 activity in the dining room. The aide indicated she would return the resident to the activity so her nail care could be completed. The care plan, with an update of 5/4/06, directed "Keep fingernails clipped and filed to avoid scratching trauma." At 8:00 am, on 7/11 and 7/12/06, the resident's fingernails were observed. The nails on both hands had been polished but the nails had not be trimmed and smoothed. They continued to be long, jagged and rough. This caused the potential for development of a skin injury inside the right hand and scratching trauma.	F 312	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 313 IDENTIFIED RESIDENT: # 9: Concerns were addressed during the survey process. Resident now has hearing device and glasses on as she allows. Resident has had appointment for replacement of hearing aides set. This citation has the potential to impact all residents requiring the assistance of glasses or hearing devices to promote quality of life. The following measures have been taken to assure ongoing compliance: • Direct care staff educated regarding assuring residents had assistive devices in place as needed • Audit of resident needs completed and aide Cardex updated to reflect assistive devices • Unit Managers will audit through observations for ongoing compliance	
F 313 SS=D	483.25(b) VISION AND HEARING To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and family interview, it was determined the facility failed to ensure residents received vision and hearing assistive devices needed to maintain their abilities for 1 of 13 sample residents (#9). Findings include:	F 313		

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F 313	Continued From page 24 Resident #9 was admitted to the facility on 1/20/03 with diagnoses of Alzheimer's disease, hypothyroidism, cancer, and osteoporosis. Her 5/20/06 significant change MDS stated "hearing aids present and used."Her 6/28/06 significant change MDS stated her vision was impaired and she "hears only in special situations." The hearing aids were not noted in the 6/28/06 MDS. Resident #9's 6/15/06 Care Plan included, "Hearing impairment bilateral ears...insert hearing aides in bilat{eral} ears before breakfast and check for proper functioning and clean as needed." Additionally, the care plan included, "Altered vision...glasses on in AM off at HS Q {every} day." During observations on 7/10/06 intermittently from 10:12 a.m. - 12:55 p.m., 7/12/06 intermittently from 6:15 - 1:30 p.m., and on 7/13/06 from 8:00 - 9:30 a.m. resident #9 was not noted to be wearing hearing aids in either ear. On 7/11/06 at 8:30 a.m. an amplification device consisting of a small metal box, cords and headphones was noted on her bedside table. A Care Plan update of 6/26/06 stated, "Very hard of hearing, hearing aids being fixed, {decreased} communication. Staff to use hearing device to communicate. Instruction sheet provided c {with} device on bedside table in pt. {patient} room." With the exception of the noon meal on 7/12/06, staff were not noted to utilize the hearing device to assist resident #9 with communication during any activity or task over approximately 9 hours of intermittent observation. During interview on 7/13/06 at 10:45 a.m., a family member reported resident #9 had several incidents of missing and	F 313	QUALITY ASSURANCE AND MONITORING: • Nurse Managers will conduct ongoing audits to assure residents have appropriate assistive devices in place • Social Services Director and Nurse Manager will conduct random audits to assure ongoing compliance • The Director of Nurses will assure compliance through observations, audits and rounds. Identified areas of concern will be addressed immediately and addressed as needed in the facility Performance Improvement Meeting. Completion Date: August 15, 2006	

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F 313	Continued From page 25 broken eye glasses, dentures and hearing aids during her stay at the facility. Reportedly, her hearing aids had been broken for the past two months. Resident #9 was observed to be without her eye glasses during the following time periods/activities: 7/11/06, 6:15 - 8:45 a.m., face washing, attempting to apply denture adhesive, dining. 7/12/06, 8:00 a.m. - 12:50 p.m., dining (breakfast and lunch), watching television. The DNS was interviewed on 7/13/06 at 11:00 a.m. and confirmed resident #9 was currently without her hearing aids and the communication device was to be used until they were repaired. She also confirmed resident #9 should have been wearing her glasses.	F 313	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined the facility failed to	F 314	F 314: IDENTIFIED RESIDENTS: • #6: Resident was referred to Occupational Therapy for review of appropriate pressure reducing devices for her contracted left hand and specifically, distended thumb. Therapy has provided a device to prevent pressure to thumb Need to check weekly skin sheets to determine if surveyor statement is correct regarding no skin checks from 6/23 through 7/10	

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F 314	Continued From page 26 ensure preventative measures were consistently implemented to prevent the development of pressure ulcers. This resulted in harm to resident #6 when she developed a recurring pressure area on her left thumb. The facility also did not ensure pressure areas were adequately assessed and consistently documented. This effected 2 of 15 sampled residents (#'s 2 and 6). Findings include: 1. Resident #6 was admitted to the facility on 7/29/99 with diagnoses of subdural hematoma, coma, quadriplegia and depression. The resident's quarterly review MDS assessment, dated 4/16/06, documented the resident required total dependence of 2 plus persons for bed mobility, transfers, toileting and personal hygiene. This assessment also indicated the resident was totally incontinent of bowel and bladder. Section M "Skin Condition" of this assessment indicated the resident had no pressure ulcers at the time of the assessment. The resident's Fall RAP summary, dated 1/25/06, documented "...Dependent on staff 2° [secondary to] quadriplegia to position & maintain all ADLs. Resident does not initiate movement..." The resident's Pressure Ulcer RAP summary, dated 1/25/06, documented "...[Increased] potential of developing or worsening of decubitus 2° medical issues & immobility. Currently area on L[eft] thumb Stg [stage] 2 plan to refer back to Dr. care. Tx [treatment] nurse currently following. Previous area L. thumb 1/19/05..." The resident's most current "Pressure Ulcer Risk Assessment Tool", dated 6/1/06, documented the resident was at high risk for development with a score of "9." A score of 12 or less represented	F 314	• #2: Resident's 3rd nail was trimmed to prevent further concerns. Resident will be seen by the podiatrist on, and will be placed on the podiatrist review for each visit if so indicated. Care plan was updated to reflect resident specific needs related to toenail care. This citation has the potential to impact all residents. The following measures have been taken to assure ongoing compliance: • Licensed staff educated regarding completion of weekly skin checks, and documentation of those skin checks • Licensed staff educated regarding identification of skin concerns, obtaining orders and implementing measures to promote healing and prevent worsening • Certified Aides in the facility have been educated regarding observing and reporting skin concerns to their Licensed Nurse and documenting those concerns on the 24 hour report sheet • Nurse Managers educated regarding auditing of nurse documentation to assure completion of weekly skin checks QUALITY ASSURANCE AND MONITORING • Nurse Managers are auditing nursing documentation to assure	

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F 314	Continued From page 27 high risk. The resident's care plan dated 2/9/06 documented, "...(09) Problem...Skin integrity, impaired: potential...R/T HX [history] of multiple skin breakdown R/T contracture risk R/T increased risk for skin breakdown ...Approach... (02) Turn & reposition Q [every] 2 hrs [hours] with dependent assist...Turn to right side and back only to prevent left thumb from touching bed...(21) Skin at risk check weekly D/T increased risk of skin breakdown..." The resident's care plan dated 2/9/06 also documented, "...(16) Problem...Skin integrity impaired: actual R/T stage II to left thumb [unreadable] D/T getting pinched in wheelchair...Approach...(04) Avoid pressure to left thumb when positioning in bed or wheelchair (05) Place gold foam wedge around left wrist when up in wheelchair---or use stuffed animal (handwritten in on 6/2/06)---so left thumb and fingers float and do not get pinned in wheelchair cushion..." Resident #6's "Nurse's Notes" contained a "Condition Change Form" dated 6/2/06 @ 11:45 am, documenting, "...Medical record review this date - resident has no skin issues..." A "Physician's Telephone Order" on 6/2/06, documented "...DC [discontinue] Centrum and Vit[amin] C re: [regarding] wounds resolved and receives 100% of nutr. [nutritional] needs via FT [feeding tube]..." On 7/12/06 at 9:10 am, the wound care nurse was interviewed. The wound care nurse stated that if residents were identified as having no	F 314	weekly skin checks are completed and documented as assigned • Nurse Managers are conducting rounds to assure appropriate pressure relieving devices are in place and effective • Wound Nurse is assessing preventive measures during wound care to assure current plan is promoting healing and preventing worsening of current skin issues • The Director of Nurses will assure compliance through review with Nurse Managers and random audits. Identified areas of concern will be immediately corrected and addressed as needed in the facility Performance Improvement meeting Completion date: August 15, 2006	

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active skin issues, the LNs on each floor were completing the weekly skin checks. The LNs documented the weekly checks on the "Medication Record" and "Resident Weekly Skin Check Sheets." She stated that she monitored the active skin issues and documented the skin checks on the "Weekly Non-Pressure Skin Condition Reports" which were contained in the treatment book.

The "Resident Weekly Skin Check Sheets" documented the following:
5/4/06 No documentation
5/11/06 "No new skin issues noted."
5/18 No documentation
5/25/06 No documentation
6/22/06 "No new skin issues noted @ this time."

There was no documentation of weekly skin checks provided from 5/26/06 through 6/21/06 and 6/23/06 through 7/10/06.

The "Medication Record" for 5/2006 and 6/2006 documented, "Order Date: 3/09/05 Skin at risk assessment q week indefinitely D/T high risk for skin breakdown. See Skin at Risk weekly check sheet to document results." The "Medication Record" provided spaces for each Thursday of the month to document staff initials as the assessments were completed. Staff initials were documented on 5/11/06 and 6/22/06. There were no staff initials documented on 5/4, 5/18, 5/25, 6/08, 6/15 or 6/29/06.

The "Medication Record" for 7/2006 documented, "Order Date: 6/29/06 Skin at risk assessment q Tuesday on day shift D/T risk for skin breakdown. See skin at risk weekly check sheet to document

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results." The "Medication Record" provided spaces for each Tuesday of the month to document staff initials as the assessments were completed. There were no staff initials documented on 7/4/06.

The following observations of resident #6 were made during the survey:

*7/10/06 at 10:16 am, the resident was observed in bed with a gauze bandage covering her left thumb. The resident's left arm was observed rigidly extended and drawn close to her left side. Her thumb was rigidly pointing downward into the bed. No positioning devices were observed to be in place to the left hand.
*7/10/06 at 10:58 am, 2 CNAs were assisting the resident with incontinent cares. The dressing to the left thumb was noted to be soiled. The wound care nurse entered the room and completed a dressing change to the left thumb. The resident's thumb was noted to have a reddened area that covered approximately the entire tip of the thumb. Inside the reddened area were 2 circular open areas approximately 1/4" in diameter each. Crusty clear drainage was noted to the thumb tip area.
*7/10/06 at 12:55 pm, the resident was observed in bed tilted to the right side. The resident's left arm was rigidly extended with her left thumb tip pressing into her thigh. No pressure relieving devices were observed to be in place to the left hand.
*The resident was observed to be without pressure relieving devices to the left hand on 7/10/06 at 1:22 pm, 1:37 pm, 2:25 pm and 2:29 pm. At each observation the resident's left thumb tip was either pressing into her thigh or into the bed mattress.

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F 314	Continued From page 30 *The resident was observed to be without pressure relieving devices to the left hand on 7/11/06 at 6:23 am, 8:05 am, 9:55 am, 11:10 am, 12:20 pm and 1:45 pm. Again, the resident was observed pressing her left thumb tip into the thigh or into the bed mattress. A "Weekly Non-Pressure Skin Condition Report" dated 7/10/06, documented, "Date of First Observation: 7/10/06, Site/Location: Lt. thumb tip sersang [serosanguinous]. Condition is:...Other: ? blister open..." On 7/10/06 at 1:00 pm, "Nurse's Notes" containing a "Condition Change Form" documented, "...Thick malformed onchyotic [sic] nails LUE/RUE [left upper extremity/right upper extremity]. Lt [left] thumb tip is open ? blister open. Podiatry appt. [appointment] pending. Tx [treatment] initiated to L[eft] thumb tip. Area [with] sersag [serosangrinous] drainage superficial..." On 7/12/06 at 9:10 am, the wound care nurse was interviewed. The wound care nurse stated she first noticed the recurring pressure ulcer to the resident's left thumb on 7/10/06. She stated she was out of the facility from 7/5/06 through 7/9/06. At that time, the wound care nurse asked the LN who worked 7/5/06, if he had noticed any new skin issues to the resident's thumb on that day. He stated the area was well healed on 7/5/06. On 7/13/06 at 9:17 am, the DON was interviewed. The surveyor reviewed observations of no pressure reducing devices to the left hand, the lack of consistent skin check documentation and observation of the pressure ulcer to the resident's	F 314		

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F 314	Continued From page 31 left thumb. The DON stated she would request for the nurse practitioner to assess the resident's pressure ulcer. On 7/13/06 at 12:30 pm, the nurse practitioner assessed the resident's pressure ulcer in the presence of the surveyor and DON. The nurse practitioner stated the pressure ulcer was possibly a stage I, approximately dime-sized with one small area of dried blood or necrotic tissue and a second small area which was possibly opened. She noted there was slight serous drainage from the wound. The nurse practitioner told the DON at that time that due to pressure from the resident's contractures, the resident always needed her "stuffed bunny" in place under her hand for pressure relief. The facility failed to ensure that pressure areas were adequately assessed and consistently documented, and that pressure relieving devices were consistently implemented to prevent the reoccurrence of a pressure ulcer to the resident's left thumb. 2. Resident #2 was admitted on 5/28/04. His diagnoses included left lower leg amputation, multiple sclerosis, depression, neurogenic bladder and a recent fractured neck of the femur. The annual MDS assessment, dated 5/20/06, indicated the resident had normal cognition and was dependent for all cares except eating. On 7/10/06 at 2:00 pm, the resident's right foot was observed with the wound care LN. The resident's toenails were observed rough, long and jagged. The skin on the tips of the toes were	F 314		

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F 314	Continued From page 32 inflamed, red. The skin on the foot was dry, flaky and peeling. On 7/11/06, at 2:30 pm, the residents foot was again observed with the LN responsible for the resident. The 3rd nail was observed with a sharp point pressing into the inflamed area of the second toe. This had the potential to cause a pressure ulcer. The LN indicated she would trim the pointed area to eliminate the pressure point. Nursing progress notes from 7/1 to 7/12/06 were reviewed and did not indicate staff were aware of the condition of the foot. No documentation indicated the physician had been notified of the condition of the foot. The problem of the redness of the tips of the toes and need for specialized toenail care was not included in the care plan.	F 314	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Health & Rehabilitation does not admit that the deficiencies listed on the CMS-Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F 315 IDENTIFIED RESIDENTS: • #4: Resident was seen by Urologist. Urologist will provide recommendations to facility for ongoing follow up after visit. Based on Urologist recommendations, facility will proceed with measures to promote continence, as appropriate. Care plan has been updated to reflect resident's refusal of toileting at night, respecting her right to choice. Resident has been educated regarding risks involved with refusal of cares. This citation has the potential to impact all residents in the facility who have a decline in bladder continence. The following measures have been taken to assure ongoing compliance:	
F 315 SS=G	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not ensure a resident who was incontinent of bladder	F 315		

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	135077	A. BUILDING _____ B. WING _____	C 07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOISE HEALTH & REHAB CENTER	1001 S HILTON ST BOISE, ID 83705

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F 315	Continued From page 33 received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible for 1 of 13 sampled residents (#4) reviewed for incontinence care. This resulted in harm for resident #4 when the resident who was previously assessed as being continent was not re-assessed or provided the appropriate treatment & services to maintain her urinary continence and prevent recurrent urinary tract infections. The findings include: Resident #4 was originally admitted to the facility on 8/30/03 and readmitted on 3/17/06 with diagnoses which included acute gastrointestinal bleed, COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), polymyalgia, and schizoaffective disorder. The resident's significant change MDS, dated 2/8/06, indicated the resident had moderately impaired cognitive skills, displayed no negative behavioral symptoms, required extensive assistance with transfers, extensive assistance of one staff member with toilet use, and was continent of both bowel and bladder function. The quarterly MDS, dated 6/14/06, indicated the resident was still assessed as having moderately impaired cognitive skills, required extensive assistance with transfers, extensive assistance of one staff member with toilet use, and displayed no negative behavioral symptoms. However, the assessment now indicated the resident was frequently incontinent of bladder. No "Appliances and Programs" were checked in relation to toileting or bladder retraining and a "Urinary tract infection in last 30 days" was checked.	F 315	• Direct care staff have been educated regarding reporting of changes in resident continence • Bladder assessments will be completed annually, or with changes of continence as noted on the MDS • MDS coordinator will notify Unit Manager regarding identified changes in continence. The Unit Manager will assess possible causative reasons for incontinence, and implement measures to address identified concerns. • Residents who are identified to have a decline in continence will be assessed per policy to determine possible causes of incontinence, and measures will be implemented to promote return to prior level of function • Residents who are not successful with the measures to promote return to prior level of function will be referred to a Urologist for follow up QUALITY ASSURANCE AND MONITORING: • MDS Coordinator will monitor for changes in continence with completion of MDS's • Director of Nurses will monitor for ongoing compliance through review of MDS's to assure residents identified to have a decline in continence are addressed timely. Identified areas of concern will be resolved immediately and	

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F 315	Continued From page 34 The resident's comprehensive care plan, dated 5/16/06, revealed a problem of "Self-Care Deficit: Toileting..." The documented approaches included, "Encourage resident to complete toileting task with extensive assist; Document Bowel Functions...; Bladder Document: C=Continent I=Incontinent." An updated care plan, dated 7/11/06, documented a "Restorative Program Referral" related to a diagnosis of "urinary incontinence/weakness." The documented approaches included "UI [urinary incontinence] exercises, see attached sheet cont.[inue] exercises 4-6 x [times] week for 4 weeks 10 reps [repetitions] per exercise." Attached to this care plan was a "Pelvic Muscle Exercise Program." Physician's orders revealed the resident was transferred out of the facility to a local hospital and readmitted the facility on 3/17/06, with an indwelling Foley catheter. According to a physician's order, the catheter was discontinued on 3/24/06. No bladder assessment could be located in the resident's record after the catheter was discontinued until 7/4/06. Further review of the resident's record revealed a "Bladder Status Evaluation" dated 7/4/06, which documented under the section titled "History", the resident had "freq[uent] UI [urinary incontinence]; had a current infection of the bladder; and used "Adult brief/diapers." Under the section titled "Current Urinary Status," it was documented the resident's usual time to use the bathroom was "upon rising" and "after meals." The assessment indicated the resident needed "to urinate during	F 315	addressed in the facility Performance Review meeting as needed Completion date: August 15, 2006	

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F 315	Continued From page 35	F 315		

the day" every "2-3 hours." The section to indicate how often at night the resident needed to urinate at night was left blank. The assessment also indicated the resident was unable to hold her bladder for 2 hours when she had to go to the bathroom and the resident did not have "a constant sensation" that she needed to urinate. The documented conclusion to the assessment indicated the resident had mixed incontinence, was on a "Habit/Scheduled toileting" program and was "currently working with OT [occupational therapy]."

Attached to the bladder assessment was also a "Bladder Voiding Pattern Record" dated 6/23/06, which revealed the following information:

"Instructions: Complete the Voiding Pattern Record as indicated. For each time application, record amount VOIDED in ml's. Document INCONTINENCE by indicating W (wet) or D (dry)." The form contained two columns, one for "Voided" and one for "Incontinent."

The form indicated the voiding pattern started on 6/23/06 at 3:00 pm and ended on 6/26/06 at 2:00 pm.

On 6/23/06 the following was documented: A "1" was marked at 5:00 pm under "Voided"; "1" was marked at 6:00 pm under "Voided"; and a "1" was marked at 8:00 pm under "Incontinent". No other times were marked for that day to indicate the resident was checked for incontinence but was dry, and no amount voided was indicated.

On 6/24/06 the following was documented: A check mark was marked at 7:00 am, 9:00 am,

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F 315	Continued From page 36 and 11:00 am under "Voided" and "Incontinent"; a check mark was marked at 1:00 pm, 4:00 pm, 7:00 pm and 9:00 pm under "Incontinent." No other times were marked for that day to indicate the resident was checked for incontinence but was dry, and no amount voided was indicated. On 6/25/06 the following was documented: A check mark was marked at 7:00 am and 9:00 am under "Voided" and "Incontinent"; a check mark was marked at 1:00 pm, 3:00 pm and 5:00 pm under "Incontinent." No other times were marked for that day to indicate the resident was checked for incontinence but was dry, and no amount voided was indicated. On 6/26/06 no bladder voiding patterns were marked for that day. The nurse's notes revealed the following information: 5/31/06 [un-timed], "Resident complaining of urinary frequency...Dipped urine it was positive for leukocytes, nitrates, glucose, ketones..." 5/31/06 [9:30 pm], "...Res[ident] started ABT [antibiotic treatment] et [and] Diflucan this p.m. c/o [complaints of] burning when urinating..." 6/10/06 [8:30 pm], "...Rec[eived] final ABT this p.m..." 6/18/06 [5:00 pm], "c/o burning, urgency upon urination. [Physician's name] ordered UA [urinary analysis] then start Septra DS i po [by mouth] x 10 days."	F 315		